IOWA: Public Health Supervision Reporting Form for Dental Hygienists

DATE(S) OF SERVICE: _____

DENTAL HYGIENIST NAME: **DENTAL HYGIENIST SIGNATURE:**

SUPERVISING DENTIST NAME:

PUBLIC HEALTH SETTING: (CIRCLE ONE)

School **Head Start** **FQHC** **PH Dental Van** **Free Clinic** **Nonprofit Community Health Center** **Federal PH Program** **State PH Program** **Local PH Program**

CLINIC/LOCATION NAME OR SERVICE SITE:

ADDRESS:

SERVICE PROVIDED	TOTAL NUMBER PROVIDED	TOTAL NUMBER CLIENTS SERVED AGES 0 -20	TOTAL NUMBER CLIENTS SERVED AGES 21+
SEALANT			
PROPHYLAXIS			
ASSESSMENT/ SCREENING			
FLUORIDE VARNISH APPLICATION			
REFERRAL TO DENTIST(S)			
EDUCATIONAL SERVICE			
OTHER, PLEASE SPECIFY:			

THIS REPORTING FORM MUST BE COMPLETED AND RETURNED TO THE IOWA DEPARTMENT OF PUBLIC HEALTH AT THE COMPLETION OF THE PROGRAM, OR IN THE CASE OF AN ONGOING PROGRAM, AT LEAST ANNUALLY. RETURN TO:

IOWA DEPARTMENT OF PUBLIC HEALTH
ORAL HEALTH BUREAU, 5TH FLOOR
ATTN: PUBLIC HEALTH SUPERVISION
321 E. 12TH STREET
DES MOINES, IA 50319-0075